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A Summary of the findings of the

High Risk Behaviour Study

From 18 cities

NACO
National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

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compiled by Mala Sinha
for the National AIDS Control Organisation
December, 1997

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FOREWORD

In the absence of a vaccine or any cure for AIDS prevention of new HIV infections remains the main strategy to contain the spread of HIV/AIDS. It has been the endeavour of National AIDS Control Organisation to generate large scale awareness regarding HIV/ AIDS/STDs, to motivate people to analyse their own behaviour, the risk they are exposing themselves to, and eventually, change their behaviour in favour of safer options.

As part of this strategy, NACO initiated a qualitative research study covering major cities. The purpose of the study is to map the patterns and prevalence of high risk behaviour related to the spread of HIV/AIDS. To start with, six groups have been identified as those at the highest risk of contracting HIV infection, namely, female commercial sex workers, men having sex with men, eunuchs/hijras, frequently travelling men, intravenous drug users and slum dwellers. Slum dwellers actually are exposed to the HIV infection because of sex work and drug use only which their living conditions facilitate. It has been observed that nearly three fourths of the HIV infections are through the sexual route. A need was felt to look into the sexual practices and preferences of people. As it has always been considered a taboo to discuss sex and sexuality in our society, misconceptions and myths around these issues abound. The study was aimed at finding out the same. In addition to locating sites and estimating number of persons practising risk behaviour, the study also identifies partners for further action whether they are NGOs, institutions or individuals.

This report is a summary of the findings from 18 cities. It only gives a national scenario of the risk behaviours. It focuses only on those findings which can be useful for intervention planners and implementers, of both Governmental and Non-Governmental Organisations. For planning any effective intervention, reference to detailed city report is strongly recommended. Every intervention has to be contextual.

While NACO can help bring awareness using mass media, behaviour change can be brought about by adopting an interpersonal approach in motivating people to search for the safer options available to them as also helping them develop necessary skills so that they can negotiate safe behaviour. NGOs can use this resource material for planning their intervention programmes in a more effective manner.

J.V.R. Prasada Rao

INTRODUCTION

The first cases of HIV/AIDS in India were detected in 1986. Realizing the importance of prompt action, the National AIDS Committee was formed the same year. The very next year; in 1987, the Government, with assistance from WHO and other multilateral as well as bilateral donor agencies mounted a response to the epidemic and launched the National AIDS Control Programme. In the initial phases, efforts were largely focused on collecting epidemiological data, particularly targeting those groups which were thought to be 'sexually promiscuous' or donating blood on a regularly commercial basis. The major components of this programme then were surveillance and screening of blood and blood products. Within a short span of 5 years, the surveillance data indicated that HIV infection is prevalent in almost all the states and Union Territories except Arunachal Pradesh. The rapid spread of the epidemic called for urgent and concerted action for the prevention and control of HIV/AIDS, and reduction of the impact of the illness. National AIDS Control Organisation (NACO), was created under the Ministry of Health & Family Welfare, Government of India, in 1992 to spearhead the implementation of a comprehensive strategy all over the country with a World Bank credit of US $ 84 million. The plan envisaged a multisectoral approach and paid special attention to the involvement of Non Governmental Organisations in its implementation.

In India, the major route of HIV transmission is sexual. Over 73% of the HIV infection is through sexual route, while over 8% is through needle sharing by intravenous drug users. Another 8% is through transfusion of unsafe blood which can be effectively controlled. The other mode is the biological one, i.e. the vertical transmission - from mother to the unborn child.

In our society, sex and sexuality have been consciously kept under wraps. We have always felt shy of discussing and dealing with the issues related to sex and sexuality. Consequently, these issues, by and large, remain surrounded by a myriad of myths, taboos and ill-founded views. Early epidemiological and behavioural information indicates the need to look into this, so far, closeted domain in more detail and to probe the high risk practices of the people.

While other modes of transmission can be plugged tightly through appropriate training and supervision of biomedical procedures, spread through needle sharing by intravenous drug users (IVDUs) and indulgence in unprotected sex with multiple partners can be contained only by making those at risk aware of it and convincing them of the need for introspection. Prevention of transmission in these cases relies completely on individual motivation to change behaviour and adopt safer options. But, before we set out to motivate people into changing their behaviour that puts them at a higher risk, we must know what that behaviour is that we wish to change and the alternative that we want to propose. We must know about those practices that put people at a higher risk, the misconceptions that would preferably be cleared, and the taboos surrounding the alternate safer options etc..

Right now we have only high figures of HIV infections. The full blown AIDS cases are still fewer. So there is a wide spread denial of the possibility that HIV/AIDS will ever be a serious problem in India. Since the high risk groups are highly marginalised and covert, most of us do not relate the speed of spread of HIV infection to the activities of

these groups. The problem appears distant to most of us who do not have an idea of the magnitude of those practising high risk behaviours. An assessment of those infected and those more likely to be infected because of their risky practices was imperative before any effective intervention strategy was formulated. Also there was a need to map the locations and magnitude of high risk groups, in order to devise purposeful intervention plans.

In addition to exploring whether we were likely to have a major epidemic and finding out about the existing behaviour patterns, there was a need to identify future partners in a variety of sectors who could undertake interventions. These could be NGOs/ CBOs/ individuals/ educational institutions/ industries or anyone who had the potential and links with the community to effectively intervene in these sensitive and intimate areas of life.

Further, it was clear that behaviour across the country was not uniform. Geographical, historical, economic and cultural factors had interplayed for generations to produce unique patterns, and hence what may be a priority need in one place may be of little consequence elsewhere. How we approach them on these sensitive and very personal issues requires lot of ground work beforehand in order to be convincing. It is important to capture these differences and tailor responses to them.

With this scenario and need in view, the National AIDS Control Organization undertook a rapid assessment to gather more information about these behaviours and map various patterns of risk behaviour. The High Risk Behaviour study was to be done in urban centres, specifically in all cities with a population of 5 lakhs and more, as well as states and Union Territory capitals.

OBJECTIVES

Although every human being is at the risk of contracting HIV, however; certain people are at a definitely higher risk than others because of the lifestyles they lead, their profession or practices. For each of the high risk group identified, city researchers were to complete the following.

1. Descriptions of the patterns of risk behaviour This will include descriptions of locations, activities, other associated groups, and vocabulary commonly used.

2. City maps showing location of high concentrations of risk behaviour. This may be residential locations, as in the case of female commercial sex workers, or places where they usually congregate, or work places.

3. Estimates of the population involved in each type of behaviour. Also prioritize the main risks in the city.

4 A description of the social and organizational network within which high risk behaviour occurs, including sources of health care and other risks. This description will be intervention oriented.

5. A list of potential future partners - NGOs / CBOs / Professional or Trade groups / other organizations working with the target groups.

Most of the high risk behaviours are not approved by the society, which forces people to keep their activities unnoticeable. Groups known to practice deviated behaviours are, generally, "marginalised" and live on the periphery of the mainstream. This has an unfortunate consequence that their needs remain unknown and are not met with. Because high risk groups are uncommunicative, which compounds the problem, they have been particularly selected as the focus of this study.

SCOPE AND SCALE OF THE STUDY

The study focused on six groups essentially, which are typical routes for spread of HIV/AIDS and which cannot be reached through existing structures and networks. The uniformed services, college youth were therefore not included, although there is high incidence of STDs among the former group, which itself is an indicator of prevalence of high risk behaviour; while the latter falls in age group most affected. The groups identified as those at highest risk were: female sex workers; frequently travelling men; men who have sex with men; trans-sexuals, hijras or alis; injecting drug users; and slum populations. The reason for inclusion of the last group was that it represented the convergence of several factors that appear to facilitate unsafe behaviour: migrant populations with high male bias in the sex ratio; absence of traditional mechanisms of social control; rootlessness and instability; poor access, especially for women, to information and services, as well as not really being a part of information sharing networks; and youth are at special risk due to a variety of influences and lack of employment. In addition to these, each city was encouraged to identify local groups who they felt were at heightened risk. Several cities thus chose to add street children also in their study. The study also sought to concentrate on those networks which we know very little about.

This study was an attempt to map the location and magnitude of a range of high risk behaviour in cities with populations of 5 lakhs and more as well as in all the State and Union Territory Capitals. Wherever possible, an effort was made to include pockets outside the city, for example, villages nearby, which service the main city for commercial sex etc. The study does not seek to be in-depth, analytical or explanatory. Its primary purpose is fact-finding for advocacy and planning. It is an exploratory study.

Large urban cities were taken up because they are perceived to be at a greater risk for various reasons. First of which is the high population density coupled with greater mobility in search of employment. This forces spousal separation for long stretches of time. Traditional social fabric is loosened and lifts the social pressure off the individual which otherwise keeps him from indulging in sanctioned behaviour. Further, the anonymity of big city and crowd gives the required cover for people to practice alternate behaviours that otherwise they would desist from indulging in. Organised commercial sex is thus more an established feature of urban centres than of rural areas. Homosexual behaviour among men is also more overtly practised in cities. Powerful underworld network reinforces availability as well as use of drugs. The urban milieu facilitates departure from established norms without being ostracized or even frowned upon.

65 cities have been identified in various regions all over the country, to be covered in this study. All states and Union Territories, except Punjab and Jammu and kashmir, will be covered. The first phase of the study was carried out in 22 cities during 1994-95.

This study does not form any value judgment on any of those practising high risk behaviour or intend to isolate these groups only as sole reservoirs of HIV/AIDS. It simply seeks to help them by developing effective communication channels with them to make them consider safer options and prevent themselves from getting infected. The endeavour of NACO and other agencies, to prevent HIV infection and reduction of its impact, does not stop at high risk groups only, but extends to everybody else.

METHODOLOGY

To facilitate conducting of the study in all the 65 selected cities, the country has been divided into ten zones. Each zone is supervised by the Regional Coordinator who is responsible for the study and the production of the report for that region.

The coordinator will have the support of a Regional Centre, an institute which will provide technical and infra-structural support for the study. The coordinator may or may not be a faculty member/individual from the Regional centre, but in either case they will work together

With the help and recommendation of State AIDS Officers, an Institute of Social Work, Dept. of Preventive and Social/Community Medicine, Dept. of Social Science, Home Science or Education was selected in each city to carry out the study. Training was conducted by a Central Training Team, in accordance with a Training guideline prepared by NACO/WHO, which included:

- an introduction to the study,
- information on HIVIAIDS, and excercises to help researchers keep away personal/ cultural biases while talking with target groups,
- qualitative research techniques, including use of role play, supervised field experience, and observation, practice in data recording and analysis.

The inputs from NACO ranged from working out the methodology of the study, drafting the protocol, identifying Regional Coordinators and Centres, preparing a training guideline, recruiting a central team, participating in the training of the researchers, providing technical assistance as needed, managing the finances and being responsible for the overall study.

Ethnographic approach was selected as primary methodology in which data are collected through direct observation and from interviewing in an open-ended informal way. For this lot of time has to be spent in the field with the target group. However; rapid assessment was mainly done through two methods - key informant system and focus group discussions. Three types of key informants were interviewed viz. type I - administrators and officers, type II - streetwise outreach workers and type III - members of the target groups. The basis for selection of the key informants was:

√ Direct expert knowledge
√ Identified as expert by different persons
√ Gives detailed, contextual information

- √ Relatively free of strong biases/prejudices
- √ Should not have tendency to exaggerate, show off knowledge
- √ Check reliability of the information given

Since it is a qualitative study, there was purposely selective sampling for interviews. The more knowledgeable persons were interviewed in depth to construct a picture of the situation. Additional and corroboratory information was collected through observation and focus group discussions.

AIM AND SCOPE OF THE CURRENT REPORT

This report is aimed to give an overview of the high risk behaviour patterns in selected cities from various regions all over the country. So far, only 18 cities have submitted their reports. This report gives a panoramic picture of all these cities from various regions. It is more representative than exhaustive. While it speaks of crosscutting trends and patterns of behaviour which appear universal in manifestation, its purpose is not to generalize about high risk behaviour but to document both commonalities as well as variations without being analytical. It only summarizes the findings of every city.

Although the focus of this report is only those findings which can have a bearing on intervention design and advocacy, however, to devise any focused, relevant and cost-effective intervention strategy, the complete city report will have to be referred to, in order to get an in-depth assessment of the situation, complete with maps of locations and activities, vocabulary used by these groups, opportunities and obstacles to interventions, and the list of potential partners (like organisation or key persons already working there) to work with. This report is not intended to help generate any intervention principles of any kind. Every intervention has to be contextual to be purposeful and effective, especially when it relates to human behaviour, more so, sexual behaviour

An effort has been made to account for as much information as has been possible to decipher from the reports from various cities, 18 of which are available. No doubt these groups viz. the homosexual/bisexual males, IV drug users, call girls etc., have carefully and consciously cultivated invisibility about them and are very difficult to get close to and get information from, however, these groups need to be researched further and more thoroughly, for little is reported about these groups and their behaviour which could be effectively used for designing any intervention. More can be learnt about the eunuchs too.

COMMERCIAL SEX WORKERS (CSW)

Almost all the cities have a different traditional backdrop against which the sex trade has been flourishing over the years like: the muzra-culture from Mughal period in Agra and Lucknow; a similar singing and dancing profession in Varanasi; the Devdasi system in Madurai, Coimbtore, Thiruchirapalli and other southern cities; establishment of the earliest film studios in Salem which attracted a number of small time dancers and acting aspirants to come and play extras in movies and additionally involve in commercial sex activities and so on. There are a few communities who are traditionally in the business of commercial sex as seen in Kanpur, Agra and Bareilley. Interestingly, they do not involve their daughters in law in this trade while their daughters are expected to carry on the trade.

However, the present day commercial sex work is broadly the same in its form in almost all the cities. Hence, in the present report the CSWs are classified into four broad categories based on the basis of their mode of operation as observed in most cities: the brothel-based, (lodge based are also included in this group); the home-based and part-time workers; the street based and the call girls.

BROTHEL BASED CSWS:

Brothels range from highly restrictive arrangement in some cities where the workers are not allowed to move out of the brothels unescorted, to contractual agreement where they have to present themselves at the time and place required by the brothel owner, which otherwise does not bind them in any other manner. Movements are particularly restricted for the girls who have been brought into the trade forcibly and against their volition. Those who are there of their own will, enjoy greater freedom of movement.

Their earnings are, invariably, controlled by the brothel owner. The workers can neither negotiate their price nor choose or refuse their clients, the exception being the city of Surat where workers, in addition to negotiating their charges, can refuse to entertain those: who appear to have symptoms of STDs ; who are unwilling to use condoms: demanding any type of sex other than vaginal; and who appear to be foreigners. However, they give a large part of their earnings to the brothel owner and the aging workers. There is some kind of emotional bondage in this case. In Agra, brothels are run collectively by CSWs themselves and expenses are shared. Even if the brothel owner is there, the price is negotiated by the CSW herself. The brothels can be very exploitative arrangements also. An extreme situation of financial bondage is witnessed in Pune and to a slightly lesser extent also in Madurai, where the workers get barely 10% and 30% of their earnings, respectively, till the time the owner recovers the price paid for the girl. The workers have no idea how much they earn. They have to serve the clients even if they are drunk, unruly and misbehave with them. They can not negotiate safe sex under such circumstances.

Mode of operation is more or less the same in almost all the cities. Customers are brought by the pimps, brokers or directed by pan wallahs, auto-rickshaw drivers, rickshaw wallahs etc. While commercial sex work is a feature common to all cities, brothels are not Many cities like Coimbatore, Trichi, Solapur and Pondicherry do not have any established brothels. Pondicherry has been altogether cleared off brothels and red

light areas by regular police raids followed by rehabilitation schemes, which does not mean Pondicherry has no CSWs. Rajkot also has a similar situation, as far as concentration in red light areas is concerned. In Solapur CSWs operate from lodges in groups.

Power Structure

Brothels are managed by a brothel owner, mostly an aged CSW who is called 'Madam' in most cities, 'Mausi' in Gujarat, 'Amma' in Madras and 'Mamiyarae' or 'Akka' in Salem and other southern cities. The brothel owner negotiates the price with the customer and manages the brothel taking care of boarding, lodging and other daily needs. The customers are brought by pimps and brokers and some part of the earnings or a fixed amount is given to them by the owner. Local gundas and muscle men are also paid by the owner who provide them protection from other criminal elements and help smooth running of their business. In most cities police is regularly paid money or provided "free sex services" to avoid police raids.

In Solapur true brothels are not there but there are lodges where lodge owners employ about 8 to 10 girls. These CSWs have greater freedom, negotiating power and take away a greater part of their earnings, however, the lodge owner takes his fixed share.

AIDS Awareness

The source of health information for most of them are the doctors whom they visit for the treatment of STDs. HIV/STD awareness varies from high in cities like Surat and Pune to negligible in a few cities, though there is partial knowledge accompanied with misconceptions about AIDS in most other cities.

Some misconceptions about AIDS:

1) ***In Chennai, it is largely believed that AIDS is like small pox and is curable while*** others ***believe it shows itself in the form of ulcers.***
2) ***it is a disease*** of ***big cities and is not a cause of concern for people in smaller cities (like Bareilley).***
3) ***Many regularly take shots of penicillin, in the belief that this will protect them from AIDS.***

Condom Usage

Condom use varies from high in certain cities to practically nil in many others. Places covered by intervention projects show high awareness and condom use. Brothel based workers, normally, practice only vaginal sex. Anal or oral sex and long foreplay are allowed only at a higher price or when hired for the whole night.

Some conceptions about condom usage:

(1) ***Condoms are for contraception only***
(2) ***usage prolongs the period of intercourse which is seen as wasting their time***
(3) ***condom usage might be seen as lack of trust in client's purity, or the sex workers might be suspected of being infected, both of which can upset clients and divert them to others.***

However, condom use is never insisted upon by the workers even if they are fully aware of the hazards of unprotected sex. Most are so desperate to have clients that they do not want to make condom use an issue while negotiating with the customer. The only exception to this is the city of Surat where it is waived only for a very high price.

"..... when a client uses condom, she will tear the tip of the condom just before the sexual act so that it ends faster."

Health Seeking Behaviour:

Brothel based workers are least conscious about their health and seldom seek qualified medical practitioners. Those who are better off go to private doctors which are closest to their place. Most get infected with STDs but never go to Government aided/provided facilities. They always prefer private practitioners for the given reasons.

1) For confidentiality: They do not want to be seen by their current or potential customers around such places. This might affect their business.
2) They don't want to face awkward questioning at government facilities. Also the treatment meted out to them is insulting.
3) They resent health workers making home visits for follow up.
4) They resent the blood tests done at Govt hospitals, lest their HIV status should become known.

Motivating Factors:

Economic pressures appear to be the main driving force behind their joining this trade. Most think they can earn better in this trade without having to work hard. Rehabilitation schemes in Pondicherry have been accepted well by only the marginal or the aging workers. The young and well off workers do not want to leave this profession. Some feel after remaining in this occupation for some time they become weak enough for any other kind of work.

Emotional reasons include sexual abuse, elopement with lover followed by betrayal. After one has been defiled by her lover, she can not go back to her family. In order to earn a living away from home, girls are forced into sex trade. It was seen in Chennai that many are lured by false promises of making them join films and later deceitfully pushed into sex trade by pimps

Demotivating Factors:

Most are used to consuming alcohol before sex work or with the customers during sex work. Some inject morphine or take brown sugar. Reasons given include; it helps them shed inhibitions; gives them energy to have sex with so many during the day and it numbs their senses making it easier on their conscience. But it also impairs their judgemental capacity and leaves them incapable of enforcing safer sex options.

They think ".....such men deserve to suffer, so why prevent them by using condoms"
or
".....its better to die than live like this".

Most workers have a negative attitude towards their own health and have vindictive and retaliatory attitude towards their customers and society in general. Also they seem to have resigned to fate and are prepared for death.

Brothel based workers are largely drawn from the lower strata of society. The lack of education and socialisation as well as improper sex education at the right time all contribute to girls joining this trade. For the same reason it becomes difficult to reach them with information and harder to convince them about their occupational hazards. Their children stay with them who are affected psychologically and joining this trade comes naturally to them. The danger of being sexually abused at an early age is more of an everyday reality for them, than just a chance.

The brothel based workers always tend to operate at places other than their native places. Because of the language barrier; effective communication is difficult. This is a natural impediment to their being in a controlling position while negotiating both price as well as safer sex options. Also the information channels become limited for them.

".....males visit CSWs as these women are willing to meet their sexual needs better by responding emotionally and also making them enjoy it. Also they have less inhibitions and provide a greater variety of sexual experiences with spontaneous responses, while their wives come from conservative environment and are taught to be submissive to their husbands and not to take initiative."

Networks:

A feature common to most cities is the rotation of workers either between different cities or among various centres in the same cities. Most cities are on the net with the big cities like Mumbai, Delhi, Calcutta and even Dubai & other Gulf countries. Reasons for rotation are; avoiding detection and identification in case of police raids; providing novelty to regular clients; to keep the workers in an alien environment where they cannot communicate with each other effectively and workers can not create allies. In most cities workers are taken to or called from neighbouring cities or towns to service clients. Some of them spend a few months or a year in Mumbai from where they go to Dubai and come back to their own city after earning lot of money. Others go to big cities to work in beer bars or to dance in restaurants. All of which suggests that these activities are not individual or even unlinked group behaviour, rather there is a major link up covering cities which makes it possible for the workers to, firstly, operate in places as far away from their native places as Surat from Nepal or Nagpur or from Orissa and secondly to keep changing places.

HOME BASED WORKERS:

Home based operations vary a great deal from city to city and so does the social and economic status of the sex workers - from those operating from slums and "chawls" and barely managing a subsistence to those enjoying fairly good social and economic status like the singers and dancers of Varanasi. They either function independently or through known and trusted brokers and networks. Sometimes even their family manages their business for them. There are communities in Agra, Bareilley and Kanpur which are traditionally in sex trade. In southern cities like Trichi, Madurai and Coimbatore young girls are initiated in to prostitution by their family as a "Devdasi". This is largely due to economic pressures, though religion makes it easier by sanctifying the practice. The family gets some amount of money for dedicating the girl to the temple and later the girls earnings are also taken by the family.

Some girls collectively hire a house in a good locality and maintain high confidentiality for which they charge highly from the clients. Some live in a quasi-family setup which is maintained by a couple. They avoid detection from both the police as well as neighbours.

"Kochiamma (not the real name), crossing middle age, took to this profession when she was 12 yrs. old. Beginning with rickshaw pullers with very low earnings, now she makes a big show with the french nationals. She has two daughters, one is a M.B.B.S. student and another is doing B.Sc.. Daughters are not aware of their mother's profession as they have been away at the hostels always."

They definitely have better access to services. While the former group does not interact much with the community the latter is highly mobile and is constantly on move.

It has been observed, women from well off families operate through trusted agents when their husbands are away. Also, school girls from affluent families contact boys when their parents are away. The fact that some of them pay the boys / men for their services, clearly indicates the non commercial nature of their activities, however, they do have multiple partners, which is of prime concern. High aspirations and a craving for luxurious living beyond the regular income of the family is a fairly common motivation to take to selling sex. While some operate through agents, others arrange weekly parties to find prospective partners.

"... women from well off families look for men and teen aged girls also look for boys when their patents are away. Motivation in such cases is, largely, search for pleasure and adventure or just male company in case of long spousal separation to satisfy their pent up sexual urge."

This group, by and large, has better control over negotiations of their service charges, choice of clients and choice of safer sex options. Some have been found to compel condom use. However, how much of this power is actually exercised depends on the monetary situation of the worker and the urgency for rapid business. In general, there is higher HIV awareness in this group. Except in case of those who belong to the lower income group, like those living in slums or those who are traditionally in this trade, the home based operators have better access to information and services, but as a group they are not easy to identify or reach. Also this group is more conscious about health and seek good health services.

"A 45 year old lady, a french national living in Pondicherry, enjoys sex by paying money. The widow hosts a party every Sunday and picks up a youngster for the following week and enjoys sex with him."

- Pondicherry

Those from lower strata, which makes a sizeable group, have the handicap of illiteracy and poverty to their disadvantage. Their awareness about HIV/STDs is negligible. Access to health services, even the knowledge of existence of the government provided facilities is minimal. Condom usage in this group is entirely the clients discretion. Access to the sources of information is poor. Only health and preferably social workers can reach these workers.

PART TIME WORKERS:

Part time workers are those who are primarily engaged in other occupations, which give them access to clients. Many a times sexual exploitation at work place by seniors and colleagues becomes the initiating factor. This pattern is common to almost all cities and widely prevalent among those holding middle and lower order jobs. Educationally and economically better off private secretaries in private companies have greater bargaining power and choice of clients on account of their personal prowess and skills. The lower order workers like, unskilled and sem-skilled workers in factories or textile mills, sales girls, construction workers, casual labourers or housemaids and cooks are regularly exploited by their managers, supervisors or employers for small favours. Often its the fear of losing their job that makes them submit to the employers or seniors. The lower the group, the

more choiceless and exploited the women. Economic constraints and day to day struggle for survival leaves them with fewer options.

This group, except a few in it, is largely unaware about HIV/AIDS. They have neither access to print or visual media nor the knowledge about various health facilities provided by the Govt.. They have no idea of the risk they are exposed to. Only social workers can reach them and educate them about the disease and condom use.

STREET BASED WORKERS:

Street based workers are generally drawn from the lowest socio economic stratum of the society and are a direct product of abject poverty. They solicit customers themselves and work absolutely independently. Theoretically, they have maximum freedom in their choice of clients and negotiating price, however, economic constraints leave them little scope to exercise this choice.

There is a marked difference between the full time 'day workers' who come from the suburbs or out skirts of the city and sell sex through the day and return in the evening to their houses to pretend they work in the city and the 'night workers' who sell sex at night and find customers during the day while selling vegetables, begging, singing and dancing on the road side or in local trains etc. Almost all are regular users of local illicit liquor or narcotics. These types are largely concentrated around the railway stations and bus stands in most northern cities like Lucknow, Kanpur and Bareilley.

Coimbatore, Trichi and Pondicherry are cities where the sex work is carried out almost entirely by street walkers. In Trichi 75% of the workers are married and most work under full knowledge of their husband who sometimes act as their broker also. Although they have complete control over their earnings, some part of it goes to the police and local gundas and drug peddlers. In almost all these cities the place of work is often filthy and unhygienic like deserted buildings, empty railway coaches, parks at night, railway platform, outside closed shops, public toilets, road side footpaths etc. In a sharp contrast to this, in Pondicherry, living conditions for the sex workers are pretty good. They dress and live well and look decent. This is partly due to the Govt.. run rehabilitation schemes which were availed by many of the workers.

Nagpur and Allahabad have the markedly visible groups of migratory tribal women from Chhatisgarh and Bilaspur respectively who come down to these cities seasonally, mainly in the lean periods after monsoon to work in the cities as casual labour. To supplement their income they sell sex indiscriminately despite having the freedom to choose.

".....having sexual intercourse with Bilaspur women cures one of STDs, hence no need to use condoms."
(a common belief among men in Allahabad)

Another group of street based workers are those working along the highways to serve the truck drivers. They generally come from villages around halt points or along highways or stay in shacks around the 'highway dhabaas'. While street workers in most cities dodge easy identification, in Pune, the street workers are identified by the peculiar wire bags they carry for which they are called "Thailiwali Bai" or "Pishwiwali Bai". They solicit clients at the bus stands and other public places.

Compared to the brothel or home based workers the street workers are least protected and most exposed to harassment by police, local 'gundas' and drug peddlers. Street workers remain highly mobile partly to avoid them. It is very difficult to contact them again.

Their own health is no priority for them. A large majority of them are regular users of country liquor or oral drugs. Condoms are preferred by some CSWs in a few cities, but even these are not consistent users. Very few insist on its use every time they have intercourse. The need to generate income is overriding in most cases, so, they do not want to loose clients on this account. The clients almost always have an upper hand on this issue. The poorest do not seek health care at all, but the slightly better off ones do go to unqualified doctors or homeopaths. Use of government provided health facilities is minimal. This group does not have good access to information. Most are illiterate and have no knowledge of HIV/AIDS/STDs. The tribal migrants are not even familiar with condom use.

CALL GIRLS:

This group varies and draws workers from middle to the upper most strata of society. They are diffused through all socio economic classes. They work clandestinely through trusted agents or brokers or independently. Hence, extremely difficult to identify as a group or even individually. This group is economically, educationally even socially much better placed than any other group of sex-workers. They also exercise real freedom of mobility, freedom to choose their clients and reserve the decision of condom use as well as place of work. They can negotiate conditions more effectively. They compromise their freedom only for a higher price.

Call girls are generally young and attractive, falling in the age group of 20 - 30. Though women of all ages and diverse background like, school/college girls, housewives, separated women, nurses, teachers, women in Govt.. or private service etc. have been observed to be functioning as call girls. Since most come from economically, educationally and socially sound families, they take to this behaviour out of their own volition. Motivation could be high aspirations, craving for luxurious living beyond their regular income.

A 16 yr. old has been in this trade for the last two years. She accepted that her father brought customers for her and she was in the trade voluntarily. She charges Rs. 200/act or Rs. 1000/night. Initially she had sexual relations with one of her boy friends, who later left and since her family knew of her behaviour, they preferred her taking to this trade.

—Agra

Anna (not the real name), a teenaged college student from a decent family, wanted to lead a luxurious life, way beyond her means. She earns upto Rs.1000/act and has a good bank balance. She tells her parents that she is going for a movie with her friends but goes to pre-arranged hotels for sex work.

—Pondicherry

Once initiated in this trade, sometimes its the threat to expose that keeps some of them trapped in the vicious circle. College girls addicted to drugs are forced into selling sex either because of their need to generate money for drugs or by the drug peddlers, who blackmail them.

Call girls either operate independently finding clients for themselves, or through trusted agents or brokers like beauty-parlours, hotel-owners/lodge owners, sometimes even respectable figures of the city manage call girls in the guise of social workers. Diversion from vaginal sex to other forms like oral or anal sex is highest in this group. Operations are usually well disguised and hidden from even the families of the girls. Most of them entertain clients in big hotels, Govt. guest houses, private company guest houses even training institutions for officers, vacant flats and bungalows.

This group is very health conscious and seeks best health services. While other CSWs go to the private services nearest to their residence, call girls prefer to go as far from their residence or area of operation as possible. Some even go to neighbouring cities for STD treatment or MTP. For reasons of confidentiality they too prefer private doctors only. Access to information and services is maximum.

Rosemary (not the real name), a good looking girl from a well off family, is addicted to taking drugs. She was in a hostel, where she got the habit of taking drugs. She left home as she did not want to live with her parents or take up a job. She has had a relationship with a woman who initiated her into commercial sex work. While in school she was getting the Indo — U.S. scholarship for her studies.

—Coimbatore

Despite there being variations in the patterns of risk behaviour, one feature emerges as common to all cities and that is the health seeking behaviour. While the poorest sex workers do not seek health care at all, the rest prefer private practitioners as they are seen as respecting their need for confidentiality, more discrete, humane, and not asking awkward questions. Women do not like to be around a place identified as treating STDs because their current or prospective clients may see them and not want to come to them as they are infected. Several go to unqualified practitioners or homeopaths. The government sponsored health facilities are not well received by those who need it the most, which is a cause for deep concern. It essentially warrants a change in the attitude of the health personnel towards these stigmatised groups. They will have to elicit the confidence of the target audience.

Condom use varies from one group of workers to the other. Very few use it consistently. Just making them aware of the disease is not sufficient, as has been observed. The seriousness of the consequences of infection has to be effectively conveyed to them. Subsequently, they must be motivated to examine their own risk behaviour and consider the safer options available. While information campaigns can make people aware, a behavioural change can be effected only through interpersonal approach. However, in all places there is great need to step up interventions, especially with the clients, as almost all reasons for non-use of condoms were linked to the client's demand, preference or perception. The women have little control over the use of condoms. Lack of independent decision is a major impediment to adoption of safer practices.

Since most sex workers are illiterate or had little education, the most effective way to reach them is through health and social workers. Some instances of resentment towards health workers also have been observed. At such sensitive places social workers can be more successful as they can win their confidence and empathy

before touching upon these very personal issues and intimate practices. Also they need to be helped in developing the necessary skills to choose and adopt safer practices.

Another obstacle to behaviour change of sex workers is the rotation of sex workers around the major cities, preventing the creation of allies and placing them in situations where they cannot communicate properly. This restricts both mobility and the ability to access information and services as well as negotiate safer behaviour The police also appear to play a restrictive role, forcing business underground through raids, and exploiting or harassing women. This also forces them to keep changing places.

The use of alcohol is very high, some even take drugs, making negotiating and the appropriate use of condoms difficult. Certain beliefs make safer behaviour less likely e.g. oral sex is considered dirty; the negative attitude to self, vindictive attitude towards clients, use of condom is seen as suspecting one's 'purity'. These are the negative views which reduce motivation for the adoption of safer behaviour. Also, there is a need to simultaneously address surrounding rural areas as there is a strong in and outflow of men and women linked to sex work. The interventions should be aimed at, both, the sex workers as well as clients.

The studies all highlighted the need to move away from stereotypes of sex workers. Many remarked that they look just like "normal girls" i.e. they do not dress differently. There are no boundaries of socio economic class. There is no clear distinction between sex workers and non-sex workers. Many do not indulge in it for money, but they do have sex with multiple partners, which could be protected or unprotected. Many couples indulge in group sex as seen in Salem. Also, there is a fluidity and toggling between working in prostitution and not, and this is significant in identifying high risk persons. Such people have to be addressed through mass media. Sex education at an early stage is also strongly indicated.

MEN having SEX with MEN
(MSM)

Though highly covert, homosexual behaviour has its sure presence in all the cities. In some cities these activities are at a fairly large and organized scale like in Chennai, Agra, Varanasi etc. In most other cities it is entirely at an individual level. The extent of the prevalence of this behaviour varies from city to city. This behaviour has been found to have an association with certain groups in each city. In most northern cities like Lucknow, Bareilley, Kanpur etc. the wage labourers, coolies, and the lowest paid workers around railway station, long route bus stands, vegetable markets and workers at transport companies indulge in this behaviour regularly. Some city reports confirm its presence in school/college hostels in Nagpur, Solapur and Pondicherry to name a few and in social institutions in Surat, Solapur and Nagpur. This is definitely not all in each city mentioned here. There might be many other groups and situations that remain unexplored and have not been documented here, in all the cities surveyed.

Estimation of the number of men practising it is impossible because these men very consciously cultivate invisibility. The reasons for their reluctance to come out in the open about their sexuality is their fear of the adverse perception of and reaction to their behaviour by the society. Most feel they are indulging in something abnormal or insane and fear denunciation from family and friends.

This behaviour also has been reported to cut through all socio economic classes. But those practising it can be classified into three categories based on the initiating factor.

1. The casual interest groups, who have sex with other males purely for pleasure or self gratification and operate within their small groups. They take to it voluntarily. They like to call their group as "cruises".
2. Those who indulge in it for money and largely play passive role and take clients indiscriminately. These can be called commercial sex workers, for their reasons are purely financial. They may not be in the trade out of choice, but once initiated in the sex work accidentally, they may remain in it, even if they find it painful and not pleasurable at all. Lower income group, especially those with irregular means of income, typify this group.
3. There is another large and fluid group which is particularly vulnerable to indulge in this behaviour- that of street children and those living in slums. They are essentially victims of sexual abuse at an early age. For them sex is for survival. They play passive role mostly under pressure or duress or threat and later start selling their services. The cleaners and helpers working on the trucks also indulge in this behaviour to please the drivers and win their favours in the form of driving lessons and later a licence.

All the three above mentioned categories may not be prevalent in each city. Fewer cities have been reported to have commercial sex workers of this nature. Most cities have these activities going on at individual basis or in smaller covert groups.

Mr.: M is a dance master and a practitioner of yoga. He has a girl friend who was his student. His relation from this girl', extended to boys too. He derives pleasure from hugging and kissing boys. He has non-penetrative sex between thighs.

- Pondicherry

The reasons cited by different men for their nonroutine sexuality vary. Some feel its the peculiar psychological make-up of both the active and passive players. Those who play passive role believe they are more feminine and like to be subjugated while those who play active roles always are believed to be strong male chauvinists who have a great feeling of extreme masculinity. They see their virility and sexual prowess as their main source of strength and wish to subjugate other males. Such men usually look for young and charming boys to play passive players for them.

"Mr. S is also a dance master. To him the feminine quality in males is more attractive than in females. Sex stimulation for him is common with boys and girls. Every night he wants sex, for which he takes boys to cinema houses, he indulges in non-penetrative sex only."

i) because they find young age itself stimulating.
ii) young boys can easily be manipulated and threatened into submission, if they themselves do not have homosexual tendencies.

School and college boys see it as part of growing-up. They want to experiment and in the absence of female company, have sex with other males. This group may not always indulge in penetrative anal sex and may prefer safer options like ejaculating between thighs. This homosexual phase soon ends for them and they may become heterosexual for the rest of their life.

There is another group which is bisexual and keep toggling between the two modes. They give the reason for this as:

1) their uncontrollable, impulsive desire to have sex that they must satiate immediately. So in the absence of any female around at that moment, they have sex with available males.
2) having sex with males infuses them with vigour and they can perform better with their wives later.

However, those men who always have sex with men say:

1) they feel attracted to males only and its mutual;
2) oral/anal sex is more pleasurable than vaginal;
3) consumption of semen makes them young and gives them more vigour;
4) oral sex is a treatment to get relief from an itching sensation in the throat.

Those indulging in this behaviour are, largely, between 17-35 years of age, though a few cases of over 60 years also have been reported. Their activities are usually at an individual and intimate level. Most do not prefer strangers, rather only reliable ones for their partners, while those working as commercial sex workers are quite indiscriminate and entertain anyone, as and when they pick up clients. These services are available at lodges/hotels. Also the room boys and attendants extend such services.

Whatever be the driving force behind their sexual preference, they are extremely uncommunicative about it. They are very reluctant to share information about their partners or their sexual experiences with men. The bisexuals have no problem talking about their sexual encounters with females but they are shy of speaking about homosexual experiences.

The usual places of homosexual acts are school/college hostels, prisons, deserted places, public urinals, cinema halls etc.. Juvenile homes for delinquent children, destitute homes and prisons have been found to be places of sexual abuse of inmates by the institution personnel. In prisons, undertrials have been reported to have been forced into homosexual act by the prison personnel as well as other inmates. The regular inmates routinely indulge in homosexual activities, which is on a voluntary basis. Nevertheless, its the unprotected penetrative multi partner sex which exposes them to a high risk of contracting HIV infection.

Condom use is very uncommon among these groups. Following are the reasons given:

1. *condom thwarts pleasure;*
2. *majority cannot use condoms because such encounters are random and un-planned. Availability of condoms at such moments is a big question;*
3. *condoms are seen as a contraceptive not required with males;*
4. *consumption of semen is believed to be healthy;*
5. *HIV does not spread through homosex, it spreads only through sex with female;*
6. *bachelors do not want to be seen as using condoms, so they never pick up Govt. provided free condoms.*

While the scanty information milched out indicates divergent patterns and preferences; from stray and individual activity to sex work on commercial scale; from penetrative anal to non penetrative or oral; and from strictly homosexual to bisexual, however, a few points do emerge which need attention.

i) all those indulging in homosex have multiple partners compared to the heterosexual ones.
ii) most are bisexual and have sex with women too, either with single or multiple female partners.
iii) condom use is extremely low and not seen as necessary.
iv) there is a marked preference for young boys indicating a dire need to educate adolescents too.
v) Most social institutions are willing to participate in health education campaigns, but are reluctant to promote condom use among their inmates.
vi) needs community action as this activity is so much under wraps that identification of this group is extremely difficult. Homosexuals are largely educated and have better access to information and services. They can be reached, though not personally, but through print & visual media. They use good health services. For STD treatment most prefer reliable and discrete doctors, who can be non-judgemental about their sexual behaviour.

ALI / HIZRAS / EUNUCHS

Living on the margins of social mainstream, this group faces an ambiguous existence. Alis/hijras are a very cohesive and well organised group living in established and strictly adhered to hierarchy. They do have rules and codes of conduct and good network with an excellent information system. They, generally, prefer staying in groups. The only exception is the city of Pondicherry, where they enjoy good social interaction and are not treated as social outcasts. This could be the reason why they do not live in groups segregated from the society. They also have normal occupations like those of vegetable-sellers, gardeners, cooks and peons. But some of them still indulge in sex work.

In most cities, Hizras have some occupation or the other, whether full time or part time, in addition to sex work. In some cities, especially in the northern cities of Agra and Kanpur, they just sing and dance and collect money. While in southern cities like Trichi, Coimbatore and Salem, they sell vegetables and flowers, work as unskilled or semi-skilled labour too. But in Pune they work as full time sex workers and are much better off than their female counterparts. They have greater freedom too.

Only a few are well off and have a middle class-like life style. Their earnings are managed by the 'guru' or the 'leader' of the group who provides boarding, lodging and takes care of the daily needs of all those living in the group. Part of the earnings are shared by all. Though they have rules and codes regarding sexual activities, most indulge either in multiple partner sex in serially monogamous relationships or through commercial sex work itself. They mostly indulge in anal or oral sex. Motivation is both economic and their personal need to satisfy their urge.

Their clientele comprises mostly those who enjoy anal sex or want to experiment and look for variety in sexual experiences without inhibitions, like the college students. There are a few who like to have sex with hijras only. Their annual festivals draw both Alis and their customers in large congregations. These occasions can be used to reach them with information.

Political activity involves participation in elections. They do canvass for certain candidates.

Misconceptions regarding STDs.

1. They make Cannabis pills with Arsenic and lead, which they believe can cure all diseases.
2. "Semen consumption keeps them fit".

Misconceptions regarding condom use:

1. *condoms are for contraception, not to be used for anal sex.*
2. *Most customers feel HIV/STD is not related to Alis. Its a problem of the female sex workers.*
3. ***Most are not even aware of HIV/AIDS.***

Health awareness:

A very small percentage is health conscious and seeks proper health services, like the Alis of Chennai go to qualified doctors at good nursing homes. A majority of them show much apathy towards health issues. They frequently have STDs, ulcers in their mouth and skin eruptions for which they seek unqualified practitioners and homeopaths who are more considerate and humane in their behaviour towards them. Other related habits are use of alcohol and sometimes oral or smoking drugs which is a positive hindrance to negotiations of safe sex. They, invariably, avoid Govt. services as they find the attitude of health personnel derogatory and often insulting towards them. Condom use in this group is negligible.

Attitude of the community is more dismissive towards them as a small and negligible group however, this group is most easily identified and well-organised group which could be targeted for information. However, further research is required.

FREQUENTLY TRAVELLING MALES (FTM)

Truck drivers, are the single largest group of frequently travelling males which invariably indulges in a variety of high risk behaviours viz. multi-partner sex with female sex workers, which appears to be every driver's prerogative, relatively less frequent homosexual activities with their cleaners and helpers, regular intake of alcohol which increases their vulnerability to indulge in unprotected sex and occasional use of drugs too.

1. *A strong belief associated with their being promiscuous is that driving for long hours accumulates heat which only liquor and sex can release from the body.*
2. *Other reason for their behaviour are long absence from home and spouse for weeks at a stretch.*
3. *Cheap and ready availability of CSWs along highways and halt points also make it convenient and alluring for them to resort to sex workers.*

Some even maintain a second wife at a frequently visited halt point. Most drivers make extra cash by carrying passengers short distances which adds to their disposable income. And this is invariably spent on buying sex and liquor. Another motivating factor is the coaxing by older drivers. It has developed as a subculture among this group. Peer pressure plays a big role in diluting the inhibitions of newcomers to this occupation. The possibility of using the truck itself for sex makes it further convenient as they do not have to hire a place nor fear raids or harassment by police.

Many use the cleaners and helpers for homosexual activities in return for favours like teaching them how to drive and get a licence to drive. A positive finding is that drivers are very conscious about their health. Though misconceptions abound, but they do fear STDs and do take precautions according to their beliefs like washing the genitals with dettol and soap water. or lemon juice or with their own urine after having sex. Most seek STD services and buy medicines too. Some even take Roscillin' capsules themselves, or get their blood test done for STDs. They are not fully aware of AIDS, its transmission, and the consequences. All that needs to be done is, their misconceptions be dispelled and correct knowledge provided. Condom use is increasing. A few cases are reported where they go to the extent of using tubes meant for sealing diesel leaks, in case they run out of condoms. Still there is a sizeable group which despite being aware of STDs is not careful about safe sex.

One encouraging feature is that this group has, so far; responded the best to intervention programmes. Their sources of information are posters, banners, hoardings, and circulation of pamphlets related to AIDS awareness distributed by field workers of voluntary organisations. In Chennai a positive feedback has been reported. Drivers passing through the NGO covered check posts showed significant difference in AIDS awareness and higher sales of condoms at and around the check-posts which is largely because of

(i) information sharing among themselves.
(ii) few incidents of AIDS-related deaths among drivers.

While education is a positive factor that encourages behaviour change, fear of death acts as a deterrent.

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The other frequently travelling males are not so easily identifiable as a group, like : the sales representatives; auditors; businessman; executives; Govt. officials; railway personnel; film distributors; various union leaders and owners of finance companies.

Most of these prefer call girls at the hotels or guest houses, where they stay. Since this group is, by and large, better educated group, condom use is higher. Though many avoid condom use with call girls, as they feel call girls come from good families and cannot be infected. They have good access to information sources and specialised health services. Not much is know about their sexual preferences.

INTRAVENOUS DRUG USERS (IVDUs)

This group is highly elusive, for their activities are not well accepted by the society. The only risky aspect of their behaviour is needle-sharing, which is a known route of HIV transmission. All city reports do not document this aspect very clearly, so a clear picture of the pattern of this behaviour does not emerge. However it is strongly indicated that there is a grave problem cutting across all the strata of society, which is possibly growing and needs urgent attention.

Not all cities are reported to have injecting drug users, or may be they remain unexplored. Oral drugs, however are in common use in almost all cities. The cities which do have injecting drug users, frequently use a combination of Tidigesic, Fortwin, Calm pose and Phenargan. All of which can easily be procured from local chemists without prescription. Those who indulge in this behaviour individually use disposable syringes. However, those who use in groups are at a risk.

Others get the drugs injected at clinics by compounders, who do not use disposable syringes. Whether they sterilize the needles and syringes is not known.

"A group of medical students from Pondicherry has been reported to be using new disposable syringe every time they make a syringeful for the group which is used by all. All of them are confident that they cannot get infected, because use none of them is a carrier."

It has been observed that, normally the drug users start with brown sugar and gradually drift to Tidigesic which is injectable. Needle sharing is quite common in Chennai. The drugs commonly used here are morphine, pethidine, Avil, Pentazoine, Diazepam and Bupreonorphine. Since, almost all drug users gradually drift towards stronger drugs, which are invariably injecting ones, the number of injecting drug users is likely to increase and not decrease unless there is large scale, protracted intervention.

Additional risk behaviour is multi-partner sex after taking drugs. Initially drug use heightens sexual desires after intake. Gradually it dies off and makes them poor performers.

The only redeeming feature is that most want to come out of this habit and they have full support from their families. De-addiction centres can play a useful role so can the community itself. However, this needs to be further researched, for a lot remains to be known about them.

ANNEXURE

TABULATED CITYWISE SUMMARY

OF THE

FINDINGS FROM 18 CITIES

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
VARANASI	1. Age-group, approx. no. pick up points	Young, unmarried, 600-900 CSWs	60-90 workers, talented singers, dancers	Roadside, pan-tea shops, truck halts	Their contact points are high class hotels
	2. Management and control	Live in small groups with brokers/ pimps who negotiate charges from clients	Manage themselves but sex work is extremely clandestine	Work independently, give money to police and rail personnel	Work through trusted brokers have full control over earnings. Charge highly.
	3. Their earnings from this activity	Highly bargainable, Rs. 10-300.	Charge a handsome amount	Varies from Rs. 20-400	
	4. Clientele / interacting group	Vast range of local and travelling males from lower and lower-middle socioecono. group, truck/taxi/bus drivers	Highly selective about clients, only affluent people who may call them for musical performances too	Truck/taxi/tempo drivers	Highly secretive operations, only rich people hire them
	5. Condom usage and other habits.	Largely unprotected vaginal sex, condom usage is only about 50%		mainly unprotected sex of all forms depending on the money given	All kinds of sex but condom usage is high. Quite normal
	6. Interaction with community	Practically nil, most workers are rotated to avoid formation of allies	Enjoy fairly good social and economic status, have normal interaction		
	7. Motivating/demotivating factors to join the trade	Many are forced in this trade, reasons are largely economic		Mostly Bangladeshi refugees, purely economic reasons. Seldom seek health services, no AIDS/STD no awareness	seek luxurious lifestyle and have high aspirations seek best health services, aware of AIDS/STDs
	8. Health care practices/ knowledge/services available	Most are aware of AIDS, do not use govt. provided condoms, buy quality condoms from market.			
	9. Networks	Rotate workers between Kanpur, Mumbai, Allahabad and Calcutta			
	10. NGOs, CBOs, other groups	Marie Stopes Clinics, Manav Seva Kendra, Gudia, Mr. Khairati Lal			

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	Call girls
	11. Age-group, approx. no. pick up points	4000-5000 CSWs, 15-40 yrs.	25-40 yrs., along highways. 15-50 yrs. for House-maids	15-35 yrs. Rly. Station, vegetable market (beggars, veg. Sellers)	200 workers, 18-40 yrs. cinema halls, hotels, Rly. station
	12. Management and control	Brothel owner (Madam) manages business, pays the police, brokers bring clients, musclemen give protection.	Independently, around dhabas	local musclemen protect them in lieu of money or free services	Work through trusted agents or brokers
	13. Their earnings from this activity	Varies from Rs. 30-200 on clients' curiosity		Rs. 10-20	Rs. 300-5000
BAREILLEY	14. Clientele / interacting groups	Forces personnel, ITBP, CRPF, BSF, PAC, govt. officers, police, truck drivers	trucks drivers while house maids service their employers	RPF personnel, coolies passengers, labourers, rickshaw pullers	Businessmen, executives, politicians, police officers and students
	15. Condom usage and other habits.	According to clients preference, some regularly use condom, most take alcohol	Never keep condoms, depends solely on clients	Never use condoms, most have alcohol	High condom use, alcohol use is common
	16. Interaction with community	Actively involved with political parties, local leaders and elections, move freely	Normal, move freely, involve with Pol. Parties and in elections	Normal, move freely	Work secretively, it does not affect their social status
	17. Motivating/demotivating factors to join the trade	Some are traditionally in sex trade, others for money	To supplement their income	To supplement their income	Either economic pressure or just longing for good life. Seek good health services.
	18. Health care practices/ knowledge/services available	Most stock condoms, marginal awareness about AIDS, conscious about STDs, seek private doctors, often unqualified	Seek RMPs and allopathic doctors for STDs but seldom complete treatment, not aware about AIDS	AIDS/STD awareness nil seldom seek health services	AIDS aware, but miscon-ceptions abound. Strong network of their musclemen who give them protection in a discrete manner
	19. Networks	Service the clients of neighbouring cities and towns also.			
	20. NGOs, CBOs, other groups	No NGOs working here			

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
LUCKNOW	1. Age-group, approx. no. pick up points	16-40 yrs. 7500 CSWs, mostly dispersed through the city	2000 CSWs	12-35 yrs. 2000 CSWs, veg. Market, Rly.Stn., bus stand, taxi stand, hotels, transpt. Agencies work independently	17-25 yrs. 1500 CSWs cinema halls, beauty parlours, restaurants
	2. Management and control	Madam manages business, brokers pimps, musclemen give protection	operate through a senior woman		
	3. Their earnings from this activity	—		Rly. Personnel, RPF, GRP, Police, coolies, passengers, vendors, No condoms used, alcohol and sometimes narcotics used. Move freely within their area, musclemen keep discrete vigil on the singer/beggars.	frequently travelling businessmen, executives, govt. officials
	4. Clientele / interacting group	Include police personnel	Most are forced into this trade		
	5. Condom usage and other habits.				
	6. Interaction with community	Most have gone underground, keep changing places to avoid identification	Taken to neighbouring towns like Raibareilley, Barabanki, Sultanpur	Most are forced into it by brokers, or are poverty driven.	
	7. Motivating/demotivating factors to join the trade				
	8. Health care practices/ knowledge/services available			Strong under world network of criminals involved in buying & selling of girls, luggage theft, fraud etc.	
	9. Networks	Service clients of neighbouring towns like Raibareilley, Barabanki, Sultanpur, Jagdishpur etc.			
	10. NGOs, CBOs, other groups	No NGOs working here			

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
AGRA	1. Age-group, approx. no. pick up points	20-40 yrs. 500-600 CSWs	16-40 yrs. 100 CSWs	22-40 yrs. 600 CSWs, cinema hall, Raja Ki Mandi operate through brokers, or former clients, fully independent in fixing price, but give a share to brokers.	25-30 yrs. 200-250 CSWs, cinema halls, beauty parlours, through contact men, or independently, especially the foreign girls.
	2. Management and control	'Madam' controls the brothel, many brothels are managed by CSWs themselves, earnings shared by brokers, local goondas, female bodyguards, and police	manage themselves or family does, generally taken by the family, or the worker keeps all in case independent		
	3. Their earnings from this activity	Rs. 20-200, for whole night 500-2000, Rs. 5000-10,000 for virgins	higher than brothel girls for they provide more confidentiality to clients all kinds	Rs. 20-50 per act, more for full night	vary from Rs. 200-500 per hour, or Rs. 200-1000 per night. Men from middle and high socioecono class, foreign tourist girls go for auto-drivers among others. Very low condom use, have both vaginal and oral sex, 25% are alcoholic
	4. Clientele / interacting group	vast range of locals, tourists, travelling males, truck drivers		Lower-middle class men	
	5. Condom usage and other habits.	condoms use entirely dependent on customer's preference, only vaginal sex practiced, regularly consume alcohol	never push condom use nor prefer, only vaginal sex practiced, alcohol is taken regularly	Customers can use condoms if they have, which is rare, otherwise not. only vaginal sex.	
	6. Interaction with community	most keep to themselves, in one locality they sometimes participate in social and religious functions	some have invested their money in the market, move freely, but avoid neighbours	Go back to their villages and families in the morning, normal interaction	Their identity is strictly confidential, have normal interaction within community
	7. Motivating/demotivating factors to join the trade	some are kidnapped and forced others cheated into entering the trade, many work willingly for money	one community is traditionally in the trade, rest for money seek private doctors	Most come from lower socio economic group and work only few days a week to supplement family income	Easy money is the prime attraction, some are pushed by the family, foreign tourists for pleasure or money
	8. Health care practices/ knowledge/services available	never force condom use, aware about AIDS, but do not take it seriously. Almost all seek private doctors only for STDs, though govt. services are available			

AGRA	9. Networks	no networks within the city, however they rotate workers between Mumbai, Delhi, Calcutta	Many go to Delhi, Mumbai and Calcutta to work in beer bars and for sex work and earn a lot, this community generally involved in various underworld activities like kidnappings, selling/buying girls, rapes, frauds etc.		Strong network of contactmen who keep the operations as well as identity of girls confidential, can be approached only through personal contact.
	10. NGO, CBOs, other groups	VACH (Voluntary Action for Community Health), AADHAR, All India Women's Conference, Marie Stopes			

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
KANPUR	1. Age-group, approx. no. pick up points				
	2. Management and control	Brothel owner takes away half the earnings, brokers also take their share and some money is paid to the police also.	Managed by family in case of those traditionally in the trade.	Are mostly displaced brothel workers, solicit clients on the streets and manage their customers themselves	Negotiate their charges, place of sex work themselves and are have full control of their activities, operate through contactmen
	3. Their earnings from this activity	Rs. 50-200			
	4. Clientele / interacting group		Lower economic group	Lower income group	Travelling trades,
	5. Condom usage and other habits.	Condom use negligible, never insist, most are regular consumers of country liquor "Mahua" which	Extermely low, since their family occupation is making country liquor "Mahua", they are regular consumers of it.	Negligible condom use	Higher condom usage, alcohol consumption is high

		they make themselves.	Face social isolation, new comers to their locality are seen with suspicion		Normal, since their sex activities are clandestine
	6. Interaction with community				
	7. Motivating/demotivating factors to join the trade				
	8. Health care practices/ knowledge/services available	Conscious about STDs, Govt. facilities closeby, but seek private doctors. AIDS awareness negligible.	Are involved in other criminal activities too, workers from here go to Agra, Delhi and Mumbai also to work in the brothels.		STD awareness is high, AIDS awareness marginal
	9. Networks				
	10. NGO, CBOs, other groups	NSS, Rotary club, Lion's club, Community Health Centre, Mariumpur, Public Health Information Bureau.			

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
ALLAHABAD	1. Age-group, approx. no. pick up points	250-300 CSWs, operate from hotels and lodges also	Contact-lady "Sanchalika" chooses clients and settles charges and takes part of the earnings, about 30% or girls manage themselves collectively, no sharing of charges	Vary from educated college girls to casual labourers from 'Bilaspur'	14-40 yrs.
	2. Management and control	Madam or "Naika" settle the price & chooses clients, musclemen provide security services. Police, high officals and advocates patronise them		Solicit customers themselves, have complete decision making power	"sanchalika", called "bhabiji" or "aunty" by CSWs, fixes clients and place and take away 30-40% or they work on their own
	3. Their earnings from this activity	Rs. 20-300 per act lasting 10-30 min., depending on the age and looks of worker			Rs. 100-2000 for one time act

	4. Clientele / interacting group			Vast range of men.	Rich business men and high officials by better looking and educated workers.
ALLAHABAD	5. Condom usage and other habits.	Very low, though some stock condoms, depends on client's preference, some take morphine injections	Not very high, but some insist and may refuse those unwilling to use condoms, most take liquor, morphine injections	The lowest group, Bilaspur women, not even familiar with condom use, educated ones also use occasionally	Insist on condom use
	6. Interaction with community	Move freely within their area, under touts' strict vigil, those having just one rich, steady patron have greater mobility in the community		Normal, they move freely	Move freely, have contacts with highly placed people
	7. Motivating/demotivating factors to join the trade			Some indulge for pleasure, others for money	
	8. Health care practices/ knowledge/services available	Generally hide their diseases, and go to obscure MTP facilities often unhygienic. No STD services, Govt. Women's hosp. is closeby, but private medical services are used by the workers		Poor ones do not seek health services at all. Among the clients there is a belief that "one gets cured of STDs by having sex with the Bilaspur women."	Seek private health and medical facilities, govt. facilities used by only lower-middle class call girls
	9. Networks	Rotate workers between Kanpur, Varanasi, Mumbai and Dubai			have liaison with high police and govt. officials, advocates, influential businessmen too
	10. NGOs, CBOs, other groups	SOUP (society for under privileged)			

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
SALEM	1. Age-group, approx. no. pick up points	150-200 CSWs		Bus-stands, construction labouers' pick-up points, cinema halls.	Textile mill workers, college girls (150 CSWs 15-25 yrs.)
	2. Management and control	Brothel owner is called "Mammi", "Perusu", "Maamiyarae" or "akka" controls earnings. Brokers also run brothels. Local rowdies are also paid regularly for security	Either broker gets clients and takes commission, if clients directly come to their homes, entire money goes to the CSW	Either through brokers or independently. Have full control over earnings, though commission is given to broker.	Independently, or through contact-lady, have greater control over their activities and earnings
	3. Their earnings from this activity	Rs. 500-5000/ week, depending on age & looks. Workers also ask for tips during sex work	Upto Rs. 1000	Rs. 50-200 per day.	Rs. 1000-1500 per day.
	4. Clientele / interacting group	Mostly govt. servants including high officials, also young boys from nearby towns during holidays, weekends and festivals			Mill-workers sell sex to owners, managers, supervisors. College girls, rich business men, govt. officials, students
	5. Condom usage and other habits	90% consume alcohol	Condom use is high and insisted upon by workers, many take alcohol	CSWs stock condoms with them, but are rarely used by clients.	
	6. Interaction with community	Those who come voluntarily move freely, those who are kidnapped/ bought remain under vigil	Clandestine operations, do not affect their interaction	Since they keep their activities under cover, interaction is quite normal.	Normal interaction, their activities are kept secret
	7. Motivating/demotivating factors to join the trade		Since most are from middle to upper classess, either for luxurious living or for fun	Economic pressures are the main reason	
	8. Health care practices/ knowledge/services available	Take penicillin/ampicillin shots daily, mostly from unqualified doctors, to avoid STDs	seek good medical services, but private ones.	Marginal HIV/AIDS awareness, seek private, unqualified homeopathic doctors	Have regular medical check-ups with private qualified doctors.
	9. Networks	Brokers keep exchanging girls	Remain unnoticed and	(one "Chottaiyan	Their activities go

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	10. NGOs, CBOs, other groups	between some 10-15 brothels in the city ----------	work largely on individual basis.	Doctor" is particularly popular) for STD	unnoticed by the police.

CITY		COMMERCIAL SEX WORKERS
CHENNAI	1. Age-group, approx. no. pick up points	3000 CSWs of all types, in the evenings at bus stands and other public places, attract clients themselves or are brought by pimps, then go to restaurants or cinema houses then go to lodges that are conducive to their activities
	2. Management and control	
	3. Their earnings from this activity	Rs. 50-150 per client, depending on, nature of customer-regular or first timer, length of time and customer's ability
	4. Clientele / interacting group	
	5. Condom usage and other habits	Easy access to condoms, but not preferred by both CSWs and clients, for various reasons, like (I) it will indicate lack of faith in each other's purity and repel them (ii) it increases the coital time, thus wasting their time. ".....one worker indicated that, when a client uses condom, she will tear the tip of condom just before sexual act, so that it ends faster." Most take alcohol regularly.
	6. Interaction with community	
	7. Motivating/demotivating factors to join the trade	Economic as well as emotional compulsions. Once stigmatised they can't come out of this trade. Also they think this work gets them easy money
	8. Health care practices/ knowledge/services available	Many believe taking monthly penicillin is protection enough against AIDs. Almost all suffer from STDs at some time or the other. Seek private health services, but keep servicing clients even during the treatment. Not concerned about their clients contracting the disease.
	9. Networks	
	10. NGOs, CBOs, other groups	ACCEPT, AIDs Research Foundation of India (ARFI), ASCOWED, Citizens' forum, Deepam Education Society for Health, Educational Multi-media Association, Indian Association for the study of STD, Madras Christian Council

for Social Services, Media Foundati n, Prakriti, Madras Institute of AIDS Prevention and Education.

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	STREET-WALKERS	CALL GIRLS
	1. Age-group, approx. no. pick up points	-------	-------	Bus stands, under flyovers, behind Rly. Station	-------
	2. Management and control	Under complete bondage of brothel owner, or in a contractual agreement. No choice of clients or charges. Pimps and brokers too take their share, so does the police.	Individually managed have complete control over earnings and choice of clients, but economic constraints leave little scope for exercising them. Choice of clients and charges reduced when operating through brokers.	Openly solicit clients at public places. Have complete control over negotiating price and choice of clients as well as condom use but it hardly counts as an advantage considering their severe socio economic compulsions.	
	3. Their earnings from this activity				
MADURAI	4. Clientele / interacting group			Clientele is drawn, mainly, from poor sections.	
	5. Condom usage and other habits	Never keep condoms, do not realize the protective potential of condoms, most take alcohol, some take spurious drugs.	Never encourage condom use, ignorant about the protective role of condoms against AIDS/ STDs.	Neither aware of HIV or STDs nor familiar with condom use. Also they are used to taking illicit liquor, "Arrack".	
	6 Interaction with community	Their mobility not restricted within the city. Few NGOs encourage positive participation of CSWs in 'programmes they organize, otherwise not seen in public gatherings. They are not organized	Mobility is highly restricted, they do not want to reveal anything about their occupation to the neighbours, avoid interacting with them. They are widely dispersed and not organized.	Normal interaction within their community, highly mobile within the city. Take part in all festivals keenly take part in political rallies and are affiliated to political parties.	
	7 Motivating/demotivating factors to join the trade				

MADURAI	8. Health care practices/ knowledge/services available	Fully equipped govt. STD department with a separate STD ward in addition to HIV/AIDS screening centres exist. CSWs prefer private services, also some attend medical camps organized by NGOs. Take penicillin shots once, sometimes thrice, a week, after having sex with several partners. Marginal HIV/AIDS awareness. Sources of information, are, TV radio, local NGOs' programmes, also media.	Adequate govt. medical services available, yet unqualified quacks, qualified private doctors, NGO clinics are sought even for serious illnesses and STDs. But participate in NGO sponsored health campaigns and periodic checkups held regularly.	Awareness on health issues is nil. Health is no priority for them. No access to sources of information. Total apathy towards health issues. Seek quacks and traditional healers, if at all. Govt. facilities are available, but never approached.	-------
	9. Networks		Brokers operate all over the city and give addresses of the workers to the prospective clients.	No networks involved, only simple understanding between CSW, and the beat police of nearest police station.	
	10. NGOs, CBOs, other groups	IMAGE (Institute of Mass Awareness, Guidance and Education), Anaiyur, and CSED.			

CITY		COMMERCIAL SEX WORKERS
PONDICHERRY	1. Age-group, approx. no. pick up points	14-50 yrs. No brothels or group Commercial Sex Work found here, either operate from residence or solicit clients at pickup points like bus-stands, Rly, Stn., cinema halls and other busy public places. Sometimes reckshaw-pullers play guides or husband-cum-broker.
	2. Management and control	Operate individually, mainly from their residence or take clients to pre-appointed hotel/lodges. No full time brokers found here. Have complete control over their earnings. If at all, the brokerage is paid by the customer.
	3. Their earnings from this activity	Rs. 100-500 per client. or Rs. 1000/ day.
	4. Clientele / interacting group	Mostly floating tourists, govt. servants, businessmen, travelling representatives, truck drivers, young college students etc.. Men from neighbouring dry areas come for liquor, followed by search for ladies and sex.

	5. Condom usage and other habits	Despite having easy access to condoms condom use is not very common. Very few educated call girls insist on condom use but the clients remove the condom during intercourse. Almost all regularly take alcohol, either alone before sex work or in company of the customer.
	6. Interaction with community	Interaction is quite normal for many of the CSWs as they live in respectable residential localities and function secretly. Also they dress well, live well and look pretty decent, an antithesis to the stereotype of CSWs, as known to most people. Their children are also getting good education from good institutions. The lower income group of CSWs, however, are easily identifiable by their make-up and way of dressing up. Their interaction within their own community is not very restricted, nor is their mobility. Those operating as call girls enjoy good social position, as their activities remain secret.
	7. Motivating/demotivating factors to join the trade	Easily earned money, luxurious lifestyle without much hassles is the main motivation. Rehabilitation schemes, with govt. subsidies, free house pattas, loans etc., were not well received by most. Only the aging and the marginal CSWs could be brought out of the trade by these offers. The general living conditions of most of the CSWs are very good in Pondicherry, so is their social position, in general.
PONDICHERRY	8. Health care practices/ knowledge/services available	Very good Govt. provided specialised medical services are available all over Pondicherry, yet private doctors/Homeopaths are preferred by most CSWs. Govt. run STD clinics give free treatment and medicines. So, the lower sections of CSWs consult private doctors and come for medicines and prolonged treatment to these facilities. Condom use is not very common, though there is awareness about HIV/AIDS/ STDs through print and visual media, do not show extraordinary interest in preventive measures. However there is free availability of condoms and services in the city. Most CSWs, particularly the HIV carriers, have retaliatory attitude towards their clients and society in general, since the former feel that the latter is responsible for their social condition.
	9. Networks	Ever since the CSWs have been dispersed because of police action, they are not an organized group. Only some hotels and lodges carry on their clandestine liaison with CSWs. Strong nexus with politicians. Almost all confessed to have protection from leading political party. After a police raid they are bailed out by the women's wing of leading political party.
	10. NGOs, CBOs, other groups	No NGOs working in Pondicherry, only one govt. sponsored Women's Home for Destitute and CSWs.

CITY		BROTHEL-BASED	HOME-BASED/ PART TIME	STREET-WALKERS	CALL GIRLS
TIRUCHIRAPPALLI	1. Age-group, approx. no. pick up points	Very few brothels with 3-4 girls some operate from lodges.	They are dispersed through various localities in the city.	Bus-stands, Rly. Station, busy market streets.	Live in posh apartments. Clients are serviced at good hotels.
	2. Management and control	Managed typically by the Madam, taking away about half of their earnings. Those in lodges manage themselves, only clients are brought by part-time middlemen on commission basis. In some towns around Trichi, college girls, housewives, casual labourers work on a part time basis through these brothels. They have a choice of clients, also get larger share of earnings.	Mostly from lower sections, they operate on their own, at times with family support. Sri Lankan refugees form a large group in this category. Some are initiated into prostitution as "devdasi" where earnings are controlled by the family.	Have full control over their earnings which are meagre. Solicit clients themselves on the roads and busy public places and are taken to nearby lodges or private houses, the owners of which rent out their rooms for such activities.	Though their deals are fixed by their trusted brokers and agents, they reserve the right to choose clients, charges and place of work etc.
	3. Their earnings from this activity	Rs. 100-300 per night or Rs. 1500-2000 for accompanying clients out of station for 5-7 days. Bottom price range is Rs. 25-50 per client.	Range from Rs. 10-50 for those servicing for those servicing truck drivers, Rs. 50-70 by others who operate individually. Sri lankan girls earn upto Rs. 300 per day.	Rs. 10-50 in some areas, while in other areas their charges range from Rs. 50-75 for a single shot, or Rs. 100-1000 per night.	Rs. 250-300 per act, or Rs. 1500-2000 for 5-7 days from out of station clients
	4. Clientele interacting group	Businessmen.	College boys, truck drivers,		Generally rich businessmen or govt. officials.
	5. Condom usage and other habits	Condom usage is never a precondition in any group of sex workers, it might be seen as lack of trust in other's purity, although they are displayed at the place of sex. Many take alcohol regularly.			

	6. Interaction with community				
	7. Motivating/demotivating factors to join the trade	Economic pressures, sexual abuse by family members or police in case of refugees were the main reasons or forced into it by unscrupulous husband.	Undergo frequent medical checkups and take penicillin shots thinking its prevention enough against the more virulent STD, that is AIDS. The partial AIDS awareness comes from visits to doctors or through T.V.	While the poorest ones, servicing truck drivers, and the lower socio economic groups are not aware of HIV/AIDS or STDs.	
	8. Health care practices/ knowledge/services available	Some have heard about AIDs but not HIV, think its just another curable STD. Specialised Govt. facilities are scarce in and around Trichi. Private services are sought, largely for reasons of confidentiality.			
	9. Networks	CSWs are dispersed and not concentrated or organised, largely individual or small scale operations.			
	10. NGOs, CBOs, other groups	Trichi Multipurpose Social Service Society, Sisters of the cross-Society for Education and Development, Khajamalai Ladies Association, Anbalayam.			

CITY		COMMERCIAL SEX WORKERS
COIMBATORE	1. Age-group, approx. no. pick up points	No particular place for brothels. Sporadic brothels, 75% CSWs are street workers. Bus stands, Town halls, cinema halls, Railway stations, over bridges under bridges, fly-overs are the main areas of operations.
	2. Management and control	Most are independent of brokers. However, lack of organisation and security network makes them more exposed to harassment from local gundas and drug peddlers, who recognize them. Some bring their customers to the nondescript lodges which are conducive to this business, while those who cannot afford the room rent, use public toilets, parks or bus stands at night. Most come from surrounding towns. To avoid identification they go to towns other than their native. They directly solicit clients in the evening. They have complete control over their activities and earnings.
	3. Their earnings from this activity	40% of them, those operating through lodges, earn Rs. 500-1000 per day. Those operating through brokers have to spare Rs. 200/ day for them. Street workers earn around Rs. 150-200/ day, on certain days goes upto Rs. 1000-1500. All of them, invariably bribe the police as well as other criminal elements who become a nuisance for them.
	4. Clientele / interacting group	Tourists, businessmen, farmers who come to sell produce, truck drivers, coolies, textile labourers etc. Young college students also come to them, but, there is no discrimination among the customers.
	5. Condom usage and other habits	Do not have any reservations against condom use, but go by clients' preference. Sometimes the place of sex work, like public toilets, is not conducive to condom use. Most take alcohol.
	6. Interaction with community	90% of the CSWs come from surrounding villages, some from neighbouring states also. Sex work does not affect their interaction with their native community, since it remains secret.
	7. Motivating/demotivating factors to join the trade	
	8. Health care practices/ knowledge/services available	There are govt. as well as private health services available, both of which are used by the CSWs for treatment of STDs. Street workers sometimes prefer homeopaths and RMPs who claim to have sure treatment for all diseases.
	9. Networks	

	10. NGOs, CBOs, other groups	No NGOs are active in this city except Sri Avinashilingam Educational Trust Institutions.

CITY		BROTHEL-BASED	HOME-BASED/PART TIME	CALL GIRLS
PUNE	1. Age-group, approx. no. pick up points	17-35 yrs. (minor girls are housed away from brothels to avoid arrests during police raids), 3000-4000 CSWs.	Called the "Thailiwali Bai" or the "Pishwiwali Bai", they solicit clients at the bus stands. They hail from lower income groups or slums.	School/college/hostel girls, married women from lower and middle class families, operate from lodges, hotels, vacant flats and bungalows.
	2. Management and control	Mostly Nepali girls bought for Rs. 15,000-20,000, or Devdasis from Karnataka are found in the brothels under complete financial bondage of the owner. They do not know how much they earn. No choice of clients at all.	Entirely independent operations.	Manage their activities themselves or through part time brokers. Over 90% lodges offer rooms to CSWs to carry on sex work, while the owners and managers work as brokers. They have great extent of freedom in their functioning.
	3. Their earnings from this activity	They are given a small part of their earnings. However, once the price of the girl has been recovered, she can stay independently in privately hired accommodation and manage her business as well as earnings herself.	--------	--------
	4. Clientele / interacting group	Industrial workers, auto Rick. drivers, slum dwellers, casual labourers, school and college students.	--------	College students, executives of companies, businessmen, govt. officers etc.
	5. Condom usage and other habits	Are familiar with condom use but cannot enforce condom use even if they wish to. Entirely depends on clients' preference. Most remain under influence of alcohol.	--------	
	6. Interaction with community	Remain under strict vigil. Can not move out of the brothels.		Normal interaction, good mobility, and generally they maintain a good standard of living also. This group's

				Activities are covert, so they are not stigmatised either.
	7. Motivating/demotivating factors to join the trade	Most are forced into the business, since they are kidnapped or cheated into joining this trade. They are mostly from lower sections of society and are illiterate, do not have many choices or ideas about how to get out of it.		Largely money for a luxurious lifestyle, sometimes fun and pleasure, especially those seperated from spouse for long stretches, even threat to expose them keeps in the trade.
	8. Health care practices/ knowledge/services available	They do not have the power to negotiate safe sex. For STD treatment they go to Municipal Corporation Hospital and also collect condoms from there. This is the only place where brothel based CSWs do not get enough money from their owner to afford consulting private doctors. Counseling facilities are also provided there. They are aware of HIV, hence reluctant to give blood samples to the hospital. There have been a few AIDS deaths among the CSWs.	The industrial workers, who are their clients, hide their disease, because it can jeopardise the chances of those working on daily wage basis.	Seek good private health services, generally which are far away from their residence. Some girls go to other cities for MTP. The priority for the clients of this group is quick recovery from STDs, and are not very receptive to counselling. They might be aware of STDs/AIDS, but after consuming alcohol, their power of judgement is blurred and safe sex becomes a remote possibility.
	9. Networks	Brokers bring girls from various states, as far as Nepal, to sell them to brothel owners. They also provide them security services. They do have a nexus with the police.		
	10. NGOs, CBOs, other groups	Indian Health Organisation (IHO), Vance Vicks.		

CITY		BROTHEL-BASED	STREET-WORKERS/PART TIME	CALL GIRLS
NAGPUR	1. Age-group, approx. no. pick up points	40% of the CSWs - 18-25 yrs., 25% are 25-35, 10% are 35-40, 10% are 40 & above. About 5% are minors, below 17, mainly from Orissa well demarcated red light areas, some of which house only teen-aged girls. 700 work from these areas, while an equal number is diffused through the city.	Mostly the tribal women from Chhatisgarh, who come to the city during lean season, to work as casual labourers in the vegetable market. They pick up their clients from there. Construction labourers and house maids are another sexually exploited group, largely by their employers, who also supplement their income by sex work.	2000 call girls from low income families, victims of sexual abuse, and those looking for easily earned money for a comfortable living. Work through vacant apartments, deserted parks, hotels and even their regular workplace.
	2. Management and control	Brothel owner, usually called "Mausi Bai", keeps 6-7 girls. The poorer Orissa girls have little choice of clients. Some aspects of sex act like, full stripping, active participation are negotiated with the client, and tips asked for the same. However, there is no scope of negotiations with the pimp or owner about the share in earnings, as that is decided by owner only.	Solicit clients themselves, and have complete freedom to choose, negotiate the price and other modalities, however, the need to generate income is all-consuming, and they indulge in sex work indiscriminately.	Have full control and choice is theirs. They do not work under anyone's pressure.
	3. Their earnings from this activity	Rates vary from Rs. 15-30 for darker Orissa girls, to Rs. 40-300 for good looking Gwalior girls. Charges for unprotected sex are higher, so are for the ugly looking, physically handicapped or alcoholic clients.	----------	----------
	4. Clientele / interacting group	Half the clientele is local, most of whom are engineering students.	----------	Their colleagues at their work place, floating population of business men, executives, college students etc,
	5. Condom usage and other habits	Condom are freely available, yet the usage is not very high. Firstly because, they do not want to loose clients on that account, secondly, the language barrier hampers effective communication. 75% are used to alcohol. 3-4% take brown	Totally ignorant about the risk of unprotected sex. Also condoms are not freely available to them. Condom use is negligible.	

	sugar.		
6. Interaction with community	Move freely, most of them visit places of their respective regious regularly. Their interaction is limited to only those groups which support their business, the rick, wala, paanwala. Brothel owner, pimps, brokers, police personnel, doctors and quacks. But can not communicate well with most people, since most are from other states and are illiterate. However, this is the only city where the CSWs are organized. They call it "Amrapali Sangathana", which lays down a few rules for their trade.	Often they indulge in sex work with full knowledge of their husband. Theie interaction is not, in any manner, affected by their sex work. Since they come to the city seasonally, they do not create too many alliances here, except those required for their occupation.	These CSWs do not have very good social status as they are not well accepted by those who come to know of their activities. Also many remain in stress and tension because of their promiscuous way of life and the need to maintain secrecy about their work. They avoid interaction.
7. Motivating/demotivating factors to join the trade	Most have been deceitfully pushed into this business. Abject poverty of the tribals of orissa is another factor.	Generating money is their prime objective.	Reasons vary from economic to emotional.
8. Health care practices/ knowledge/services available	No govt. sponsored specialised STD services available here. They visit quacks or private doctors for they want quick relief from their ailments, otherwise they will be out of business. These also happen to be their source of health information.	No medical services available around their area of operation. Seldom seek qualified doctors.	Aware of AIDS/HIV/STDs insist on condom use. They carry condoms with them. However, some customers offer more money for unprotected sex, which may be accepted or refused.
9. Networks	There is evidence which indicates the nexus with high police officials as well as politicians.		
10. NGOs, CBOs, other groups	No NGOs working in this city for the CSWs.		

CITY		COMMERCIAL SEX WORKERS
SOLAPUR	1. Age-group, approx. no. pick up points	No typical brothels. 12,000 CSWs in all in the city. Operate from lodges or live collectively in "chawls". Pick up points for street walkers are bus stand, Rly. Staion, cinema theatres and in front of the chawls they live in.
	2. Management and control	The lodge owners are full time brokers and manage clients. They take 25% of their earnings. CSWs are in complete command of other modalities like price, condom use even place of work in case of call girls. Call girls operate through trusted and influential contact persons. Street walkers solicit clients themselves on the pick up points mentioned above.
	3. Their earnings from this activity	----------
	4. Clientele / interacting group	----------
	5. Condom usage and other habits	----------
	6. Interaction with community	Call girls keep their business confidential. Also they come from respectable and known families of the city, so they enjoy good social status.
	7. Motivating/demotivating factors to join the trade	----------
	8. Health care practices/ knowledge/services available	Call girls are well paid and seek the best health facilities. But their prime concern is confidentiality, so they often prefer going to Pune for treatment or MTP. They always seek qualified doctors. The lower income group of CSWs seek the general hospital. Most are not even aware of the medical services available in the city. However, there are STD screening/diagnostic and treatment facilities available in the city.
	9. Networks	----------
	10. NGOs, CBOs, other groups	"INTERAID", Mr. Vijay Thakur, Mr. Jakhav
SURAT	1. Age-group, approx. no. pick up points	20-40 yrs. (90% are 20-28 yrs.) 30-40 brothels having 350-400 active sex workers in well demarcated area. Most are from other states than Gujrat. Upto 75% are from Maharashtra, followed by 17% from Nepal. Street walkers solicit clients around hotels near Rly. Station. Such workers come mostly from slums. Girls come from neighbouring towns in the day time to sell sex through pimps and brokers in the lodges and hotels.
	2. Management and control	Brothel owner is called "Mausi" and takes 50%, 10% goes to the senior CSWs called "didi". The worker gets only 40% of the earnings. No pimps. Workers directly negotiate with the clients. Have real power of choosing clients, fixing charges as well as enforcing condom use.
	3. Their earnings from this activity	Service 10-12 clients per day. Rs. 20-25 per act, or Rs. 200-300 per night.
	4. Clientele / interacting group	Mostly unskilled/semi-skilled workers at diamond factories/textile mills. Govt. officials, executives, businessmen, politicians, even doctors take them away for whole night to some hotel.

CITY		COMMERCIAL SEX WORKERS
	5. Condom usage and other habits	Condom use is insisted upon and waived only for a high price. Only vaginal sex is practiced. CSWs reserve the right to refuse services to those: visibly foreigners; refusing to use condom; demanding anal or oral sex; with symptoms of STDs.
	6. Interaction with community	Minimum to nil interaction with neighbours, though they have peaceful relations with them, they have diverse cultural and religious background, but they celebrate all festivals together.
	7. Motivating/demotivating factors to join the trade	Initiating factors are, mostly, poverty and need to support their families. They do not accept rehabilitation measurers, as they have seen such efforts failing in the past. Their experience is that they are stigmatised and never accepted in the mainfold of society, which makes alternative occupation impossible.
	8. Health care practices/ knowledge/services available	Corporation and govt. run facilities are close to them, but they prefer private doctors and facilities for they are well received there. Also these are their source of health information and not mass media. HIV/AIDS & STD awareness as well as condom use is encouragingly high.
	9. Networks	They do pay the police to avoid harassment, and the local gundas to buy peace and their help required for the smooth running of their business.
	10. NGOs, CBOs, other groups	No NGO working with them. Shri Jevabhai is running a local organisation of brothel based CSWs.
BARODA	1. Age-group, approx. no. pick up points	100 brothel based workers, 100-150 street-walkers, who can be found near Railway station, bus stands, and other bazaars in the heart of the city. Those servicing the truck drivers are called "highway queens". The highway 'dhabas' or 'hotels' provide them rooms for carrying out their activities. Call girls operate mainly from big hotels or guest houses.
	2. Management and control	Call girls pay commission to the hotel owners, managers and room boys, who get them clients. The call girls as well as the brothel based workers are drawn from higher and middle socio economic strata and work through brokers, who can be auto-rick. drivers, hotel managers etc., while the street walkers are largely from lower income families and solicit clients themselves. Most workers have complete freedom to choose their clients.
	3. Their earnings from this activity	----------
	4. Clientele / interacting group	Clients of street walkers are mainly labourers and daily wage earners. Those operating on highways service truck drivers and cleaners. Brothel based and call girls serve the businessmen and high officials.
	5. Condom usage and other habits	Most are well aware of condom use and have an easy access to the same, they never insist on its use for the fear of losing clients. They assume males do not like to use condoms.
	6. Interaction with community	----------
	7. Motivating/demotivating factors to join the trade	----------
	8. Health care practices/ knowledge/services available	----------

CITY		COMMERCIAL SEX WORKERS
	9. Networks	----------
	10. NGOs, CBOs, other groups	Gujarat AIDS, Cancer and Narmada Bachav Trust, AIDS Army, AIDS counselling clinic, SSG Hospital, Nayee Roshni.
RAJKOT	1. Age-group, approx. no. pick up points	20-40 yrs., estimated between 50-150 CSWs. Women from surrounding villages come.
	2. Management and control	No organised brothels. Most have been cleared or dispersed by the police. They remain mobile to avoid identification by police. Some engage CSWs to operate from their residence and take away nearly half of their earnings. They can be called as brothel owners. But this is, often, a temporary and clandestine arrangement. There are no pimps. The CSWs have no choice of customers, however, they negotiate the price directly with the client, 40-50% of which goes to the owner. The call girls operate through agents in the hotels, who maintain a photo album of the workers.
	3. Their earnings from this activity	Rs. 125-150/day for brothel based CSWs. Rs. 50/act or Rs. 1000/night for the call girls.
	4. Clientele / interacting group	----------
	5. Condom usage and other habits	Though condom use is not forced, the workers are aware of the preventive potential of condoms. Normally they use Indian brands provided by Rajkot Municipal Corporation, but they, keep imported condoms too, for which they charge heavily. They too respect the clients preference.
	6. Interaction with community	They do not move around the city much, nor do they interact with the neighbours. They only come out of brothels either to go to the market or to serve a client at a prearranged place. They hire only known rickshaw walas for commutation.
	7. Motivating/demotivating factors to join the trade	Since the workers are mostly from lower income group only, the main reason for selling sex is economic. Though some have been brought into this trade from other cities too. Call girls are generally educationally and economically better off than the brothel workers.
	8. Health care practices/ knowledge/services available	There is one municipal corporation run dispensary, in addition to many private clinics near the brothel area. The CSWs visit all these facilitites, but trust, mainly, two doctors for treatment of STDs. An HIV/AIDS intervention programme was started here, but many CSWs escaped the blood tests as they did not want to be tested for HIV. The reason they give for avoiding the intervention programme is, they do not want to leave their profession as it is well paying.
	9. Networks	There is a reported nexus between some hotel owners and the CSWs, who bring clients to the latter.
	10. NGOs, CBOs, other groups	Only a group of municipal doctors have worked for the CSWs so far.

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